Filing at a Glance

Company:	ProAssurance Casualty Company
Product Name:	Healthcare Professional Liability (OBRA)
State:	Illinois
TOI:	11.2 Med Mal-Claims Made Only
Sub-TOI:	11.2023 Physicians & Surgeons
Filing Type:	Rate/Rule
Date Submitted:	05/29/2014
SERFF Tr Num:	PCWA-129529648
SERFF Status:	Closed-Filed
State Tr Num:	
State Status:	Under Review
Co Tr Num:	IL-2476-PRAIPH
Effective Date Requested (New):	07/01/2014
Effective Date Requested (Renewal):	07/01/2014
Author(s):	Judy Shepperd
Reviewer(s):	Gayle Neuman (primary), Caryn Carmean, Julie Rachford
Disposition Date:	06/10/2014
Disposition Status:	Filed
Effective Date (New):	07/01/2014
Effective Date (Renewal):	07/01/2014

State Filing Description:
ROUTED 6/2/14

State: *Illinois* **Filing Company:** *ProAssurance Casualty Company*
TOI/Sub-TOI: *11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*
Product Name: *Healthcare Professional Liability (OBRA)*
Project Name/Number: *OBRA Risk Management Rule Filing/IL-2476-PRAIPh*

General Information

Project Name: OBRA Risk Management Rule Filing
Project Number: IL-2476-PRAIPh
Reference Organization:
Reference Title:
Filing Status Changed: 06/10/2014
State Status Changed: 06/02/2014
Created By: Judy Shepperd
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Authorized
Domicile Status Comments:
Reference Number:
Advisory Org. Circular:

Deemer Date:
Submitted By: Judy Shepperd

Filing Description:

We are submitting for your review and approval a filing of revisions to the Healthcare Professional Liability Rates and Rules Manual which is used for policies issued through Ob-Gyn Risk Alliance, a purchasing group underwritten by ProAssurance Casualty Company.

Revised rules for your review and approval are as follows:
1. Section 3, IV. Locum Tenens: Amended rule to include that the locum tenens may cover multiple insureds up to a total of ninety days during the policy period.
2. Section 4, III. OB/GYN Risk Management Program: The Risk Management Program has been revised to be less restrictive in course options to satisfy educational requirements for this program.
3. Section 5, VI. Limited Network Related Coverage: Effective January 1, 2013, we stopped offering higher limits for Limited Network Related Coverage, or cyber liability, through policy endorsement. Higher limits coverage is now available through NAS as part of our new ProSecure group of products. ProAssurance will continue to provide basic cyber liability coverage as part of our medical professional liability policy.
4. Roman numeral corrections pages 10 and 11

Revised rating information, Section 7:
1. I. A. Rates: Deleted rating classes that are no longer in use.
2. I. B. Physicians and Surgeons Professional Liability Rates: Deleted rating schedules in limit tables that are no longer in use, based on rating classes that are no longer in use.

There is no rate impact associated with this filing

We respectfully request the effective date of July 1, 2014 for this filing submission.

Company and Contact

Filing Contact Information

Judy Shepperd, Senior Compliance Specialist
3000 Meridian Boulevard
Suite 400
Franklin, TN 37067

jshepperd@picagroup.com
615-371-8776 [Phone] 2984 [Ext]

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: Healthcare Professional Liability (OBRA)
Project Name/Number: OBRA Risk Management Rule Filing/IL-2476-PRAIPh

Filing Company Information

ProAssurance Casualty Company
100 Brookwood Place
Birmingham, AL 35209
(205) 877-4426 ext. [Phone]

CoCode: 38954
Group Code: 2698
Group Name: ProAssurance
FEIN Number: 38-2317569

State of Domicile: Michigan
Company Type: Property & Casualty
State ID Number: 12

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

Refer to our checklists prior to submitting filing (http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp).: Acknowledged
Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: Acknowledged
NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. : http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp .: N/A
Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: Acknowledged
The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": N/A
When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: N/A

SERFF Tracking #:	*PCWA-129529648*	***State Tracking #:***		***Company Tracking #:***	*IL-2476-PRAIPH*

State:	*Illinois*	***Filing Company:***	*ProAssurance Casualty Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*Healthcare Professional Liability (OBRA)*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	06/10/2014	06/10/2014

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Gayle Neuman	05/30/2014	05/30/2014

Response Letters

Responded By	Created On	Date Submitted
Judy Shepperd	05/30/2014	05/30/2014

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Effective Date Confirmation	Note To Reviewer	Judy Shepperd	06/10/2014	06/10/2014
effective date	Note To Filer	Gayle Neuman	06/09/2014	06/09/2014
Actuarial Review	Reviewer Note	Julie Rachford	06/09/2014	

SERFF Tracking #:	*PCWA-129529648*	***State Tracking #:***		***Company Tracking #:***	*IL-2476-PRAIPH*

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Disposition

Disposition Date: 06/10/2014
Effective Date (New): 07/01/2014
Effective Date (Renewal): 07/01/2014
Status: Filed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	Request to Maintain Data as Trade Secret Information		Yes
Supporting Document	Statistical Reporting Agency		Yes
Supporting Document	Marked Manual Comparison		Yes
Rate	IL OB Manual eff 7-1-2014		Yes

State: Illinois **Filing Company:** ProAssurance Casualty Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: Healthcare Professional Liability (OBRA)
Project Name/Number: OBRA Risk Management Rule Filing/IL-2476-PRAIPh

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/30/2014
Submitted Date	05/30/2014
Respond By Date	06/06/2014

Dear Judy Shepperd,

Introduction:

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

Pursuant to 50 Ill. Adm. Code 754.10, identification of all changes in all superseding filings is required. You should overstrike deleted text and underline added/changed text.

Conclusion:

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,

Gayle Neuman

SERFF Tracking #:	*PCWA-129529648*	***State Tracking #:***		***Company Tracking #:***	*IL-2476-PRAIPH*

State:	*Illinois*	***Filing Company:***	*ProAssurance Casualty Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*Healthcare Professional Liability (OBRA)*		
Project Name/Number:	*OBRA Risk Management Rule Filing/IL-2476-PRAIPh*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/30/2014
Submitted Date	05/30/2014

Dear Gayle Neuman,

Introduction:

The marked comparison showing changes in manual effective 7-1-2013 to proposed 7-1-2014 is attached to the Supporting Documentation tab.

Response 1

Comments:

Attached to the Supporting Document tab is the marked comparison showing changes in manual effective 7-1-2013 to proposed 7-1-2014.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Marked Manual Comparison
Comments:	Attached is the marked comparison showing changes in manual effective 7-1-2013 to proposed 7-1-2014.
Attachment(s):	Compare IL OB manual 7-1-2013 to 7-1-2014.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please let me know if you need any additional information to complete the review of this filing.

Sincerely,

Judy Shepperd

State:	*Illinois*	***Filing Company:***	*ProAssurance Casualty Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*Healthcare Professional Liability (OBRA)*		
Project Name/Number:	*OBRA Risk Management Rule Filing/IL-2476-PRAIPh*		

Note To Reviewer

Created By:

Judy Shepperd on 06/10/2014 08:34 AM

Last Edited By:

Gayle Neuman

Submitted On:

06/10/2014 01:22 PM

Subject:

Effective Date Confirmation

Comments:

Yes, we still wish the effective date to be 7/1/2014.

Thank you.

State:	Illinois	**Filing Company:**	ProAssurance Casualty Company
TOI/Sub-TOI:	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
Product Name:	Healthcare Professional Liability (OBRA)		
Project Name/Number:	OBRA Risk Management Rule Filing/IL-2476-PRAIPh		

Note To Filer

Created By:

Gayle Neuman on 06/09/2014 01:08 PM

Last Edited By:

Gayle Neuman

Submitted On:

06/10/2014 01:22 PM

Subject:

effective date

Comments:

The Department of Insurance has now completed its review of this filing. You previously requested the filing be effective July 1, 2014. Is that the date you still wish to use? Your prompt response is appreciated.

State:	Illinois	**Filing Company:**	ProAssurance Casualty Company
TOI/Sub-TOI:	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
Product Name:	Healthcare Professional Liability (OBRA)		
Project Name/Number:	OBRA Risk Management Rule Filing/IL-2476-PRAIPh		

Reviewer Note

Created By:

Julie Rachford on 06/09/2014 12:52 PM

Last Edited By:

Gayle Neuman

Submitted On:

06/10/2014 01:22 PM

Subject:

Actuarial Review

Comments:

Actuarial review complete.

SERFF Tracking #:	*PCWA-129529648*	***State Tracking #:***		***Company Tracking #:***	*IL-2476-PRAIPH*

State:	*Illinois*	***Filing Company:***	*ProAssurance Casualty Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*Healthcare Professional Liability (OBRA)*		
Project Name/Number:	*OBRA Risk Management Rule Filing/IL-2476-PRAIPh*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing Number	Attachments
1		IL OB Manual eff 7-1-2014	Pages 1-37	Replacement	PCWA-129055224	IL OB manual eff 7-1-2014.pdf

ILLINOIS MANUAL

HEALTH CARE PROFESSIONALS

UNDERWRITING RULES AND RATES

OB-GYN RISK ALLIANCE
(A ProAssurance Purchasing Group)

TABLE OF CONTENTS

* *

SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians, Surgeons and Allied Health Professionals Professional Liability Insurance written through Ob-Gyn Risk Alliance (a ProAssurance purchasing group), underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VI, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VI, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of $100,000 or more for basic limits for individual (a) rating.

C. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving $.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

A. By the Company: The earned premium shall be determined on a "pro rata" basis.

B. By the Insured: The earned premium shall be determined on a "short rate" basis.

C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, subject to proper notice.

III. PREMIUM PAYMENTS

1. Annual Payment Plan – The premium must be paid in full prior to the inception date of the policy. A discount for this payment option is available (see Section 4, Discounts, Item VII, below.)
2. Semi-Annual Payment Plan – 60% of the premium must be paid prior to the policy inception date and one installment of 40% is due six months after inception.
3. Nine Payment Plan – 20% down and eight consecutive monthly installments of 10% each. This plan requires that the policyholder participate in the Electronic Payment Plan in which premiums are automatically deducted from the policyholder's bank account.
   No finance charges or fees apply to these payment plans. The option to pay premium on other than the Annual Payment Plan may be withdrawn by the Company if the insured has failed to make premium payments when due.
4. Quarterly Payment Plan – 35% of the premium must be paid prior to the policy inception date, with second and third quarterly payments of 25% each and a final quarterly payment of 15%.
5. Quarterly Installment Option One
   a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
   b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.
6. Quarterly Installment Option Two – (35/25/25/15)
   a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
   b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

PHYSICIANS' & SURGEONS' SPECIALTY CODES AND DESCRIPTIONS

*** ***

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**All Other Surgery**
Anesthesiology	-	-	80151
Family Practitioner or General Practitioner - No Obstetrics	80420	-	-
Gynecology	80244	80277	80167
Obstetrics/Gynecology			80153
Pain Management	-	-	80475(C)-intermediate procedures
Pathology	80266	-	-

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS

AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:

a) First year resident - 25% of the appropriate specialty classification rate
b) Second year resident - 50% of the appropriate specialty classification rate
c) Third year resident - 75% of the appropriate specialty classification rate
d) Fellows and interns - 85% of the appropriate specialty classification rate

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification.

III. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

		Average Weekly Practice
TYPE	**Class**	**Hours <20 hours**
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

IV. LOCUM TENENS

Locum tenens coverage for each insured professional or insured paramedical employee is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens may cover multiple insured professionals or multiple insured paramedical employees up to a total of ninety (90) days during the policy period.

V. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VI. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,

2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,

3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

C. Reporting Endorsement Coverage

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%), plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

VII. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, all discounts/debits will apply to Reporting Endorsement premium calculations. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 65% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and the Ob-Gyn Risk Management Program credit may be combined with the part-time credit but no other credits or discounts apply.
- New Doctor Discount: up to 50%. Deductible credits and the Ob-Gyn Risk Management Program may be combined with the New Doctor Discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions.
- A-rated risks developing $100,000 or more annualized premium.

II. NEW DOCTOR DISCOUNT

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

Year of Coverage Since Training	Annual Premium Discount Per Policy
Year 1	50%
Year 2	25%
Year 3	0%

III. OB/GYN RISK MANAGEMENT PROGRAM

Ob-Gyn insureds who

(i) are members of the Ob-Gyn Risk Alliance Purchasing Group;
(ii) have committed to comply with the following requirements of the Ob-Gyn Risk Management Program; and
(iii) submit a signed Ob-Gyn Risk Alliance Compliance Statement;

will receive a 25% premium discount upon each policy issuance.

First Year Educational Requirements

Completion of the following two activities within the first policy year will satisfy the insured's requirements under the Ob-Gyn Risk Management Program and will qualify the insured for policy renewal consideration.

1) Medical Practice Site Survey
2) Online Advanced Practice Strategies (APS) Courses (or future APS equivalent courses)
   - Informed Consent
   - Risk Management Basics: Protection and Pitfalls

Current APS certificates of course completion for these activities will be honored.

Second Year Educational Requirements

Completion of two online APS courses during the second policy year will satisfy the insured's requirements under the Ob-Gyn Risk Management Program and will qualify the insured for policy renewal consideration.

1) Online course, SBAR+R: Structuring Communication in Health Care, is mandatory for all insureds. And,
   - Any one of the other online APS courses that haven't already been completed.

Current APS certificates of course completion for these activities will be honored.
ACOG Safety Certification in Outpatient Practice Excellence (SCOPE) for women's Health will also be honored.

Third Year and Thereafter Annual Educational Requirements

1) Three online courses that haven't already been completed.
2) A certification of completion from an approved course evidencing simulation training.
3) If specialty in Fertility or Gynecology only – Certificates of completion that total six (6) CME hours of coursework, in their specialty, in the last 24 months will be accepted.

IV. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	Debit/Credit
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

V. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY Deductible Per Claim		INDEMNITY AND ALAE Deductible Per Claim	
$ 5,000	2.5%	$ 5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	44.5%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

Per Claim/Aggregate		Per Claim/Aggregate	
$ 5,000/15,000	2.0%	$ 5,000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 12,750
10/30	.038	.035	.030	.024	25,500
25/75	.084	.079	.070	.058	63,750
50/150	.145	.139	.127	.109	127,500
100/300	.234	.228	.216	.196	255,000
200/600	.348	.346	.338	.321	510,000
250/750	.385	.385	.381	.368	637,500

Indemnity & ALAE Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.029	.026	.021	.017	$ 12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/750	.467	.467	.462	.446	637,500

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VI. LARGE GROUP CREDIT

For groups generating $100,000 or more in annualized manual premium, where the loss ratio for the account is less than 25%, a credit of 10% will apply. The loss ratio is to be computed based on five years of historical experience, utilizing incurred indemnity plus incurred allocated loss adjustment expense experience.

VII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

VIII. GENERAL RULES

A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.

B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. All other discounts

C. Additional practice charges will be applied to the premium after all discounts have been applied.

D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

III. PARTNERSHIP–CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician’s net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed $35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to insureds in the Program at no additional charge with coverage limits as follows:

Item 1	Network Security and Privacy Liability Coverage	$50,000 per Claim
Item 2	Regulatory Fines and Penalties Coverage	$50,000 per Claim
Item 3	Patient Notification and Credit Monitory Costs Coverage	$50,000 per Claim
Item 4	Data Recovery Costs Coverage	$5,000 per Claim
Item 5	Deductible	(none) per Claim

SECTION 6

PHYSICIAN EXTENDER, PARAMEDICAL AND ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, certified registered nurse anesthetists, nurse midwives, nurse practitioners, physicians, physicians' assistants, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153 or 80266, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.026	0.080	0.025
Surgeon's Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

SECTION 7

STATE RATES AND EXCEPTIONS – PHYSICIANS AND SURGEONS

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

Rating Class	Industry Class Codes		
3	80244	80266	80420
4	80151		
6	80167	80277	
12	80153		
13	80475(C)		

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	8,177	14,510	18,732	20,844	22,955
4	9,760	17,677	22,955	25,593	28,232
6	13,244	24,643	32,243	36,043	39,843
12	30,343	58,843	77,842	87,342	96,842
13	33,510	65,176	86,287	96,842	107,397

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	6,277	10,710	13,666	15,144	16,621
4	7,385	12,927	16,621	18,469	20,316
6	9,824	17,804	23,123	25,783	28,443
12	21,793	41,743	55,043	61,693	68,342
13	24,010	46,176	60,954	68,342	75,731

Territory 003 – Remainder of State

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	5,391	8,937	11,301	12,484	13,666
4	6,277	10,710	13,666	15,144	16,621
6	8,228	14,612	18,868	20,996	23,123
12	17,804	33,763	44,403	49,723	55,043
13	19,577	37,310	49,132	55,043	60,954

1. Claims-Made Rates by Year (cont.)

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	7,227	12,610	16,199	17,994	19,788
4	8,573	15,302	19,788	22,031	24,274
6	11,534	21,223	27,683	30,913	34,143
12	26,068	50,293	66,443	74,517	82,592
13	28,760	55,676	73,620	82,592	91,564

Territory 005 – Jackson and Vermilion Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	7,544	13,244	17,044	18,944	20,844
4	8,969	16,094	20,844	23,218	25,593
6	12,104	22,363	29,203	32,623	36,043
12	27,493	53,143	70,242	78,792	87,342
13	30,343	58,843	77,842	87,342	96,842

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	10,905	19,966	26,006	29,026	32,047
4	13,170	24,496	32,047	35,822	39,597
6	18,153	34,463	45,336	50,772	56,209
12	42,618	83,391	110,574	124,165	137,756
13	47,148	92,452	122,655	137,756	152,857

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	8,186	14,529	18,757	20,872	22,986
4	9,772	17,700	22,986	25,629	28,271
6	13,261	24,677	32,288	36,094	39,899
12	30,385	58,927	77,955	87,469	96,982
13	33,557	65,270	86,411	96,982	107,553

Territory 003 – Remainder of State

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	6,918	11,992	15,375	17,066	18,757
4	8,186	14,529	18,757	20,872	22,986
6	10,977	20,110	26,199	29,244	32,288
12	24,677	47,510	62,733	70,344	77,955
13	27,214	52,584	69,498	77,955	86,411

1. Claims-Made Rates by Year (cont.)

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	9,546	17,247	22,382	24,949	27,516
4	11,471	21,098	27,516	30,725	33,934
6	15,707	29,570	38,812	43,433	48,054
12	36,501	71,159	94,264	105,817	117,369
13	40,352	78,861	104,533	117,369	130,205

Territory 005 – Jackson and Vermilion Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	9,999	18,153	23,590	26,308	29,026
4	12,037	22,231	29,026	32,424	35,822
6	16,522	31,201	40,987	45,879	50,772
12	38,540	75,236	99,701	111,933	124,165
13	42,618	83,391	110,574	124,165	137,756

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	13,550	25,257	33,061	36,963	40,865
4	16,477	31,110	40,865	45,743	50,621
6	22,916	43,987	58,035	65,059	72,083
12	54,523	107,202	142,321	159,881	177,441
13	60,376	118,909	157,930	177,441	196,952

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	10,038	18,233	23,696	26,427	29,159
4	12,087	22,330	29,159	32,573	35,988
6	16,594	31,344	41,178	46,094	51,011
12	38,719	75,595	100,178	112,470	124,762
13	42,817	83,789	111,104	124,762	138,419

Territory 003 – Remainder of State

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	8,400	14,955	19,326	21,511	23,696
4	10,038	18,233	23,696	26,427	29,159
6	13,644	25,444	33,311	37,244	41,178
12	31,344	60,844	80,511	90,345	100,178
13	34,622	67,400	89,252	100,178	111,104

1. Claims-Made Rates by Year (cont.)

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	11,794	21,745	28,379	31,695	35,012
4	14,282	26,720	35,012	39,158	43,304
6	19,755	37,666	49,606	55,577	61,547
12	46,621	91,398	121,250	136,176	151,101
13	51,596	101,349	134,517	151,101	167,685

Territory 005 – Jackson and Vermilion Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	12,380	22,916	29,939	33,451	36,963
4	15,014	28,183	36,963	41,353	45,743
6	20,808	39,773	52,416	58,737	65,059
12	49,255	96,666	128,274	144,077	159,881
13	54,523	107,202	142,321	159,881	177,441

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of $1,000,000.

Factors for limits above $1 Million/$3 Million Primary:

	$1M/$3M Primary	
EXCESS LIMITS	Classes 1 – 8	Classes 9 – 15
$1M	0.1977	0.2535
$2M	0.3164	0.4040
$3M	0.4055	0.5169
$4M	0.4723	0.6016
$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

II. STATE EXCEPTIONS

A. Policy Issuance

If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through [Name of Purchasing Group].

B. Rules

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

B. Rules

SERFF Tracking #:	*PCWA-129529648*	***State Tracking #:***		***Company Tracking #:***	*IL-2476-PRAIPH*

State:	*Illinois*	***Filing Company:***	*ProAssurance Casualty Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*Healthcare Professional Liability (OBRA)*		
Project Name/Number:	*OBRA Risk Management Rule Filing/IL-2476-PRAIPh*		

Supporting Document Schedules

Bypassed - Item:	Explanatory Memorandum
Bypass Reason:	Refer to filing description on General Information tab.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Form RF3 - (Summary Sheet)
Bypass Reason:	N/A - not rate change involved.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Certification
Comments:	
Attachment(s):	Illinois Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Manual
Comments:	Due to the number of changes and/or corrections in this filing the entire manual has been attached to the Rate/Rule Schedule tab.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Request to Maintain Data as Trade Secret Information
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Statistical Reporting Agency
Comments:	The Independent Statistical Service, Inc. (ISS) is our statistical reporting agency.
Attachment(s):	
Item Status:	

SERFF Tracking #:	*PCWA-129529648*	***State Tracking #:***		***Company Tracking #:***	*IL-2476-PRAIPH*

State:	*Illinois*	***Filing Company:***	*ProAssurance Casualty Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*Healthcare Professional Liability (OBRA)*		
Project Name/Number:	*OBRA Risk Management Rule Filing/IL-2476-PRAIPh*		

Status Date:	

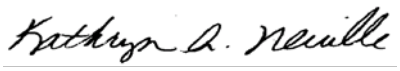
Satisfied - Item:	Marked Manual Comparison
Comments:	Attached is the marked comparison showing changes in manual effective 7-1-2013 to proposed 7-1-2014.
Attachment(s):	Compare IL OB manual 7-1-2013 to 7-1-2014.pdf
Item Status:	
Status Date:	

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Kathryn A. Neville, a duly authorized officer of ProAssurance Casualty Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing. I also certify that all changes made were disclosed, no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

I, Howard H. Friedman, a duly authorized actuary of ProAssurance Casualty Company, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.



5/29/2014

Kathryn A. Neville, Secretary
Signature and Title of Authorized Insurance Company Officer — Date

5/59/2014

Howard H. Friedman, ACAS, MAAA, Senior Vice President
Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 38-2317569 Filing Number PCWA-129529648
Insurer's Address 100 Brookwood Place
City Birmingham State Alabama Zip Code 35209

Contact Person's:
-Name and E-mail Judy Shepperd, Senior Compliance Specialist – jshepperd@proassurance.com
-Direct Telephone and Fax Number (615) 371-8776; fax (615) 986-1947

Summary
5/30/2014 12:02:31 PM

Differences exist between documents.

New Document:	Old Document:
IL OB manual eff 7-1-2014	IL OB manual adding 3rd year RM rule eff 7-1-2013
37 pages (359 KB)	40 pages (540 KB)
5/30/2014 12:02:18 PM	5/30/2014 12:02:17 PM
Used to display results.	

Get started: first change is on page 2.

No pages were deleted

How to read this report

Highlight indicates a change.
~~**Deleted**~~ indicates deleted content.
 indicates pages were changed.
 indicates pages were moved.

ILLINOIS MANUAL

HEALTH CARE PROFESSIONALS

UNDERWRITING RULES AND RATES

OB-GYN RISK ALLIANCE
(A ProAssurance Purchasing Group)

TABLE OF CONTENTS

* *

SECTION 1

INTRODUCTION

INTRODUCTION

This manual contains the classifications and rates governing the underwriting of Physicians, Surgeons and Allied Health Professionals Professional Liability Insurance written through Ob-Gyn Risk Alliance (a ProAssurance purchasing group), underwritten by ProAssurance Casualty Company, hereinafter referred to as "the Company."

I. RATES AND PREMIUM CALCULATIONS

A. Rates apply on a per incident and annual aggregate basis. The rates for the premium classifications selected by the Company or any special situations not delineated herein are those described in the Professional Liability State Rates and Exceptions Section of this manual, with a minimum premium being $500 (not applicable to paramedicals). If an individual's practice involves two or more rating territories or rating classifications, the highest rating territory or classification applies. Endorsements adding risks/exposures mid-term will be rated in accordance with the Rates and Rules in effect as of the endorsement effective date. Subject to Section 3., VI, (Rate Adjustments for Changes in Exposure) of this manual, Reporting Endorsements will be rated in accordance with the Rates and Rules in effect as of the policy effective date. Subject to Section 3, VI, (Rate Adjustments for Changes in Exposure) of this manual, endorsements effecting changes on risks/exposures currently insured will be rated using the Rules (e.g., rating classification, limits of liability and rating territory) in effect on the date of the change combined with the rates in effect on the later date of either i) the policy term effective date or ii) risk effective date.

B. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of $100,000 or more for basic limits for individual (a) rating.

C. Whole Dollar Premium Rule: The premiums appearing in the State Rates and Exceptions Section of this manual have been rounded to the nearest whole dollar. This procedure shall also apply to all interim premium adjustments, including endorsements or cancellations. A premium involving $.50 or over, shall be rounded to the next higher whole dollar.

II. CANCELLATIONS

Cancellations shall be made only within the parameters established by the State of policy issuance as framed in the Cancellation provisions of the policy including any State-specific endorsement thereto.

A. By the Company: The earned premium shall be determined on a "pro rata" basis.

B. By the Insured: The earned premium shall be determined on a "short rate" basis.

C. Removal from the State: Subject to state provisions, the policy may be canceled by the Company after the insured no longer maintains at least 75% of his medical practice within the state of issuance, subject to proper notice.

III. PREMIUM PAYMENTS

1. Annual Payment Plan – The premium must be paid in full prior to the inception date of the policy. A discount for this payment option is available (see Section 4, Discounts, Item VII, below.)
2. Semi-Annual Payment Plan – 60% of the premium must be paid prior to the policy inception date and one installment of 40% is due six months after inception.
3. Nine Payment Plan – 20% down and eight consecutive monthly installments of 10% each. This plan requires that the policyholder participate in the Electronic Payment Plan in which premiums are automatically deducted from the policyholder's bank account.
   No finance charges or fees apply to these payment plans. The option to pay premium on other than the Annual Payment Plan may be withdrawn by the Company if the insured has failed to make premium payments when due.
4. Quarterly Payment Plan – 35% of the premium must be paid prior to the policy inception date, with second and third quarterly payments of 25% each and a final quarterly payment of 15%.
5. Quarterly Installment Option One
   a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
   b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.
6. Quarterly Installment Option Two – (35/25/25/15)
   a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
   b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

SECTION 2

PHYSICIANS & SURGEONS SPECIALTY CODES

AND DESCRIPTIONS

PHYSICIANS' & SURGEONS' SPECIALTY CODES AND DESCRIPTIONS

*** ***

Column Heading Definitions

No Surgery: General practitioners and specialists who do not perform surgery or assist in surgery. Incision of boils and superficial abscesses and suturing of skin and superficial fascia are not considered surgery.

Minor Surgery: General practitioners and specialists who perform minor surgery or invasive procedures for diagnostic purposes, or who assist in major surgery on their own patients.

Major Surgery: General practitioners and specialists who perform major surgery on their own patients, or who assist in major surgery on patients of others.

	Industry Class Code		
Specialty	**No Surgery**	**Minor Surgery**	**All Other Surgery**
Anesthesiology	-	-	80151
Family Practitioner or General Practitioner - No Obstetrics	80420	-	-
Gynecology	80244	80277	80167
Obstetrics/Gynecology			80153
Pain Management	-	-	80475(C)-intermediate procedures
Pathology	80266	-	-

SECTION 3

CLASSIFICATION AND/OR RATING MODIFICATIONS

AND PROCEDURES

CLASSIFICATION AND/OR RATING MODIFICATIONS AND PROCEDURES

I. "MOONLIGHTING" PHYSICIANS

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting."

Covered "moonlighting" activities include:

A. Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

B. Full-time Federal Government employed physicians and surgeons (such as V.A. Hospital employees) requesting coverage for outside activities.

C. Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

D. Residents or fellows currently attending their training program who are requesting coverage for outside activities but only while they are enrolled in such program.

II. FELLOWS, RESIDENTS AND INTERNS

A. Coverage may be written for fellows, residents and interns practicing within the scope of their training in the teaching environment. Clinical exposure must not exceed 30 hours per week. For risks not rated on a per patient or per visit basis, the rate shall be calculated as a percentage of the appropriate specialty classification. The appropriate percentage is defined as follows:

a) First year resident - 25% of the appropriate specialty classification rate
b) Second year resident - 50% of the appropriate specialty classification rate
c) Third year resident - 75% of the appropriate specialty classification rate
d) Fellows and interns - 85% of the appropriate specialty classification rate

B. If fellows, residents and interns wish to practice outside their training program 100 hours or less per month, coverage may be written at a rate equal to 50% of the appropriate specialty classification.

III. PART-TIME AND SEMI-RETIRED PHYSICIANS

The Part-Time Discount is available to physicians and surgeons only.

A. who have at least 15 years of postgraduate clinical practice experience and are scaling back their practice in anticipation of retirement; or
B. who practice less than 20 hours per week due to family needs (caring for young children and/or ill or disabled family members); or
C. who are required to practice on a reduced basis as a result of a physical or medical condition, with the company's approval; or
D. who practice at least 30 hours per week at a hospital, community health center or other health care facility where medical professional liability insurance is provided by the facility. A certificate of insurance listing the Company as certificate holder must be presented annually for the credit to apply.

Insureds eligible for the New Doctor Discount are not eligible for the Part-Time Discount. Also, physicians employing or supervising paramedicals are not eligible for the Part-Time Discount.

This discount is intended to more accurately rate the insured who practices his specialty on a limited basis. The available discounts are:

		Average Weekly Practice
TYPE	**Class**	**Hours <20 hours**
Physician	1 to 7	50%
Surgeon	8 to 15	35%
All other		None

* Physicians and Surgeons whose average weekly practice hours of less than 12 hours will be individually evaluated by the company.

Practice hours are defined as:

- hospital rounds,
- charting and patient planning,
- on call hours involving patient contact, whether direct or by telephone,
- consultation with other physicians, and
- patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Company.

IV. LOCUM TENENS

Locum tenens coverage for each insured professional or insured paramedical employee is provided at no additional charge for up to 45 days in any policy year and provides a shared limit with the insured. The locum tenens may cover multiple insured professionals or multiple insured paramedical employees up to a total of ninety (90) days during the policy period.

V. CORPORATE LIABILITY - SHARED LIMIT

No charge will be made for entities sharing in the available limits of liability of the insured physicians or other insured organizations, providing each member is insured by the Company and the risk is otherwise acceptable.

VI. RATE ADJUSTMENTS FOR CHANGES IN EXPOSURE -- CLAIMS-MADE, RETROACTIVE, AND REPORTING ENDORSEMENT COVERAGE

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,

2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,

3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

C. Reporting Endorsement Coverage

The calculations for changes in exposure are performed by weighting the mature claims-made annual rates in effect at policy issuance for each period of differing exposures. These calculations are appropriate for changes in practice specialty or changes in rating territory that would affect a calculated rate. This method can be generalized by using the following weights and formula to calculate a rate for the upcoming year.

Number of years policy written	Claims-Made Year				
	1	2	3	4	5+
1	100%				
2	50%	50%			
3	37.5%	37.5%	25%		
4	33 1/3%	33 1/3%	22 2/9%	11 1/9%	
5+	30%	30%	20%	10%	10%

1. Mature claims-made annual rate in effect at policy issuance for the current practice and territory times the sum of the weights for the claims-made years in effect.

2. Plus mature claims-made annual rate in effect at policy issuance for the prior practice and territory times the sum of the weights for the claims-made years in effect.

For example, if a physician had practiced obstetrics and gynecology for over five years, then stopped practicing obstetrics and began to practice gynecology at the renewal two years prior to the electing the Reporting Endorsement Coverage, the appropriate base premium for the upcoming policy period would be:

Gynecology mature claims-made annual rate in effect at policy issuance times (30% + 30%), plus OB/GYN mature claims-made annual rate in effect at policy issuance times (20% + 10 % + 10%)

This method is applied in a similar manner if more than one practice change occurred during the previous four years. The components are pro-rated if the change occurred at a date other than the policy anniversary date.

VII. REPORTING ENDORSEMENTS (Claims-made only)

A. Reporting Endorsement Premium Calculation

With respect to calculation of Reporting Endorsement premium, all discounts/debits will apply to Reporting Endorsement premium calculations. If the policy is terminated during the first year, pro-rate the tail premium. For terminations during the second, third or fourth claims-made policy year, blend the applicable tail factors. The Company may refuse to offer deductible options for premium credit on reporting endorsements in the case of insufficient securitization.

B. Waiver of Reporting Endorsement Premium

The premium for the reporting endorsement may be waived as provided by the contract in force.

SECTION 4

PROFESSIONAL LIABILITY DISCOUNTS

PROFESSIONAL LIABILITY DISCOUNTS

I. MAXIMUM CREDIT

Maximum credit available per insured will be limited to 65% except for the following:

- Part-time exposure rating: up to 50%. Deductible credits and the Ob-Gyn Risk Management Program credit may be combined with the part-time credit but no other credits or discounts apply.
- New Doctor Discount: up to 50%. Deductible credits and the Ob-Gyn Risk Management Program may be combined with the New Doctor Discount but no other credits or discounts apply.
- Deductibles/Self-Insured Retentions.
- A-rated risks developing $100,000 or more annualized premium.

II. NEW DOCTOR DISCOUNT

This discount will apply only to solo practicing physicians who have never been in practice and proceed directly into practice from training, or physicians who fit within that category except for an interim period of employment not to exceed two years. Physicians who would otherwise qualify but who are joining an established group practice insured by the Company where their clinical exposure will not exceed 30 hours per week are to be submitted to the Company for rating.

Year of Coverage Since Training	Annual Premium Discount Per Policy
Year 1	50%
Year 2	25%
Year 3	0%

III. OB/GYN RISK MANAGEMENT PROGRAM

Ob-Gyn insureds who

(i) are members of the Ob-Gyn Risk Alliance Purchasing Group;
(ii) have committed to comply with the following requirements of the Ob-Gyn Risk Management Program; and
(iii) submit a signed Ob-Gyn Risk Alliance Compliance Statement;

will receive a 25% premium discount upon each policy issuance.

First Year Educational Requirements

Completion of the following two activities within the first policy year will satisfy the insured's requirements under the Ob-Gyn Risk Management Program and will qualify the insured for policy renewal consideration.

1) Medical Practice Site Survey
2) Online Advanced Practice Strategies (APS) Courses (or future APS equivalent courses)
   - Informed Consent
   - Risk Management Basics: Protection and Pitfalls

Current APS certificates of course completion for these activities will be honored.

Second Year Educational Requirements

Completion of two online APS courses during the second policy year will satisfy the insured's requirements under the Ob-Gyn Risk Management Program and will qualify the insured for policy renewal consideration.

1) Online course, SBAR+R: Structuring Communication in Health Care, is mandatory for all insureds. And,
   - Any one of the other online APS courses that haven't already been completed.

Current APS certificates of course completion for these activities will be honored.
ACOG Safety Certification in Outpatient Practice Excellence (SCOPE) for women's Health will also be honored.

Third Year and Thereafter Annual Educational Requirements

1) Three online courses that haven't already been completed.
2) A certification of completion from an approved course evidencing simulation training.
3) If specialty in Fertility or Gynecology only – Certificates of completion that total six (6) CME hours of coursework, in their specialty, in the last 24 months will be accepted.

IV. SCHEDULED RATING PROGRAM

The Company has determined that significant variability exists in the hazards faced by physicians and surgeons engaged in the practice of medicine. Exposure conditions vary with respect to:

	Debit/Credit
1. Number of years experience in medicine;	+/- 10%
2. Number of patient exposures;	+/- 10%
3. Organization (if any) and size;	+/- 10%
4. Medical standards review and claims review committees;	+/- 10%
5. Other risk management practices and procedures;	+/- 10%
6. Training, accreditation and credentialing;	+/- 10%
7. Continuing Medical Education activities;	+/- 10%
8. Professional liability claim experience;	+/- 10%
9. Record-keeping practices;	+/- 10%
10. Maintenance and utilization of certain monitoring equipment, diagnostic tests or diagnostic procedures;	+/- 10%
11. Participation in capitation contracts; and*	+ 10%
12. Insured group maintains differing limits of liability on members.*	+ 10%

In order to recognize these and other factors affecting a particular practitioner or group practice, the Company proposes to apply a debit or credit to the otherwise applicable rate dependent upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%; the maximum debit will be 25%.

The Scheduled Rating Plan will apply to individuals as well as groups of two or more physicians as the Company becomes aware of variability in the risk characteristics of the individual or group. At the underwriter's discretion, objective credits otherwise applicable to an insured will not be applied in situations where a scheduled debit is deemed necessary.

* NOTE: No credit will be given for #11 or #12 above.

V. DEDUCTIBLES

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer ($1M/$3M). Deductibles are subject to approval by the company based on financial statements to be submitted by the insured and financial guarantees as required. The amount of the deductible credit may never exceed 80% of the annual aggregate, if any. In the event where the credit exceeds 80% of the aggregate, the annual aggregate will be adjusted accordingly. This Rule does not apply to any risk when a deductible has been added for underwriting reasons.

A. Individual Deductibles

Discount as a Percentage of Rate for Applicable Primary Limit

These per claim and aggregate (if any) deductibles apply to each insured separately.

INDEMNITY ONLY Deductible Per Claim		INDEMNITY AND ALAE Deductible Per Claim	
$ 5,000	2.5%	$ 5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	44.5%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

Per Claim/Aggregate		Per Claim/Aggregate	
$ 5,000/15,000	2.0%	$ 5,000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

For other deductible amounts selected by policyholders, refer to management for rating.

B. Group Deductibles

An optional deductible which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year.

When an organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below.

Group aggregate deductible discounts apply to $1M/$3M premiums only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.020	.018	.015	.012	$ 12,750
10/30	.038	.035	.030	.024	25,500
25/75	.084	.079	.070	.058	63,750
50/150	.145	.139	.127	.109	127,500
100/300	.234	.228	.216	.196	255,000
200/600	.348	.346	.338	.321	510,000
250/750	.385	.385	.381	.368	637,500

Indemnity & ALAE Deductible Per Claim/Aggregate ($000)	Number of Insureds 2 - 19	20 - 40	41 - 60	61 - 100	Maximum Credit
5/15	.029	.026	.021	.017	$ 12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/750	.467	.467	.462	.446	637,500

C. Self-Insured Retentions

Insureds may self-insure a portion of their professional and general liability risk with the Company's policy attaching in excess of the Self-Insured Retention selected. The Self-Insured Retention limit may include ALAE, or ALAE may be paid pro rata. All such policies must be referred to the Company for special consideration.

VI. LARGE GROUP CREDIT

For groups generating $100,000 or more in annualized manual premium, where the loss ratio for the account is less than 25%, a credit of 10% will apply. The loss ratio is to be computed based on five years of historical experience, utilizing incurred indemnity plus incurred allocated loss adjustment expense experience.

VII. ANNUAL PREMIUM PAYMENT DISCOUNT

A discount of 1.5% of the policy premium will be applied if the insured pays the premium in full prior to the inception date of the policy. This discount is not available if the initial policy term is less than six months. If the full premium is not received by the Company by the policy effective date, the discount will be withdrawn, the policy will be rated without the discount and the insured will be billed for the additional premium.

VIII. GENERAL RULES

A. Discounts will only be applied to qualifying insureds at the initial issuance of such policy or at the next renewal date.

B. Discounts will apply in the following order:

1. Deductible Discount (primary premium only).
2. All other discounts

C. Additional practice charges will be applied to the premium after all discounts have been applied.

D. Corporate Liability premium will be determined after all discounts and surcharges have been applied.

SECTION 5

ADDITIONAL PRACTICE CHARGES

ADDITIONAL PRACTICE CHARGES

I. MEDICAL SERVICES PROVIDED IN A STATE OUTSIDE THE STATE OF POLICY ISSUANCE

Insureds engaging in the routine care and treatment of patients outside the state in which the policy is issued may be subject to appropriate surcharge or credit based upon rates consistent with those charged for a like risk in said state.

II. PARTNERSHIP - CORPORATION - PROFESSIONAL ASSOCIATION COVERAGE

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

Number of Insureds	Percent
2 - 5	15.0%
6 - 9	12.0%
10 - 19	9.0%
20 - 49	7.0%
50 or more	5.0%

A separate corporate limit is not available for solo practitioners. The minimum premium for separate limits for partnerships, corporations or professional associations is $1,000.

III. PARTNERSHIP–CORPORATION-PROFESSIONAL ASSOCIATION EXTENDED REPORTING ENDORSEMENT COVERAGE

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician’s net individual reporting endorsement premium, based on the number of insureds and the table in Paragraph II, above.

IV. CLAIMS FREE CREDIT PROGRAM

A physician will be considered claims free for purposes of this credit program if:

1. no loss payment has been made during the Evaluation Period, and
2. the total of allocated loss adjustment expense [ALAE] payments made during the Evaluation Period plus any Company established reserves for loss or ALAE does not exceed $35,000.

Only claims reported during the Evaluation Period shall be included in measuring the payment and reserve criteria stated above. The Evaluation Period is based upon the physician's rating class as defined in the table below and shall end on the effective date of the policy period to be rated. The Evaluation Period shall begin no earlier than the time when the physician first begins the practice of medicine following formal training (residency or a continuous period of residency and fellowships). The Company will review the claims history of each insured or applicant for the purpose of evaluating the applicability of each claim based upon the facts and circumstances of specific claims. Reported incidents that do not involve a demand for damages by a third party will not be included in the evaluation.

Class	Evaluation Period
1 – 4	10 Yrs.
5 – 9	7 Yrs.
10 – 15	5 Yrs.

The claims free physician will receive a 3% credit for compliance with the minimum Claims Free Period and will earn an additional 1% credit for each continuous claims free year thereafter up to 15% in total. However, if the physician has been continuously insured by the Company for 10 or more years, the maximum allowable Claims Free Credit that can be earned will be increased to 20%.

Credits will be applied or removed at policy inception or renewal only. Inclusion of claims history with prior carriers is subject to presentation of information acceptable to the Company. The determination of claims to be included and payment or reserve amounts to be considered will be based upon information available at the time the policy is rated, typically 60 days prior to effective date.

Notwithstanding any other provisions of this section, no insured with 3 or more claims will be eligible for a claims free credit without management approval.

V. LEGAL DEFENSE COVERAGE

The Company offers the Professional Legal Defense Extended Coverage to insured physicians at no charge.

Limits of Liability will be offered as follows:

# of insureds	"Each Covered Investigation"	"Each Policy Period"
1 - 5	$25,000	$25,000 X (# of insureds)
6 - 10	$25,000	$125,000
11 - 20	$25,000	$175,000
21 +	$25,000	$225,000

The limit of liability for "covered audits" will be $5,000 per covered insured with a deductible of $1,000 per audit per insured.

VI. LIMITED NETWORK RELATED COVERAGE

Standard coverage will be offered to insureds in the Program at no additional charge with coverage limits as follows:

Item 1	Network Security and Privacy Liability Coverage	$50,000 per Claim
Item 2	Regulatory Fines and Penalties Coverage	$50,000 per Claim
Item 3	Patient Notification and Credit Monitory Costs Coverage	$50,000 per Claim
Item 4	Data Recovery Costs Coverage	$5,000 per Claim
Item 5	Deductible	(none) per Claim

SECTION 6

PHYSICIAN EXTENDER, PARAMEDICAL AND ALLIED HEALTH PROFESSIONAL LIABILITY RATING

I. PHYSICIAN EXTENDER, AND PARAMEDICAL EMPLOYEES, ALLIED HEALTH EMPLOYEE PROFESSIONAL LIABILITY

Professional employees (other than cytotechnologists, certified registered nurse anesthetists, nurse midwives, nurse practitioners, physicians, physicians' assistants, surgeons or surgeons' assistants) are automatically included, at no additional charge, as additional insureds under policies issued to their employers. The limits of liability are on a shared basis with the employer.

The following paramedical employees may be individually covered by the Company by payment of an additional premium or covered elsewhere through a program deemed acceptable to the Company with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available on a shared-limits basis or with separate individual limits. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Physician Class Codes 80420, 80151, 80153 or 80266, as specified, for the applicable claims-made year and limits of liability.

(Paramedical employees written on a shared-limits basis will be charged a fourth year claims-made premium regardless of retroactive date and the shared-limits factors stated above will always be applied to a fourth year claims-made premium.)

Employee	(Factors based on 80420)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Physician's Assistant (PA)	0.026	0.080	0.025
Surgeon's Assistant (SA)	0.041	0.1250	0.037
Certified Nurse Practitioner (CNP)	0.042	0.128	0.041

Employee	(Factors based on 80151)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Anesthetist (CRNA) – not part of an insured group	N/A	0.350	0.126
CRNA employed by an insured group - separate limits basis	N/A	0.250	0.090
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists between 2:1 and 4:1	0.150	N/A	N/A
CRNA employed by an insured group – shared limits basis with ratio of CRNAs to anesthesiologists no more than 2:1	0.075	N/A	N/A

For CRNAs employed by an insured performing pain management procedures, apply the above factor to the 80475(C) ISO code and applicable rate class.

(If the ratio of employed CRNA's to Anesthesiologists exceeds 4-to-1, the Company may decline to insure the risk, or apply an additional premium, at its sole discretion.)

Employee	(Factors based on 80153)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Certified Nurse Midwife (CNM)	0.116	0.350	0.116

Employee	(Factors based on 80266)		
	Shared Limits Factor	Separate Limits Factor	Non-insured Vicarious Liability Factor
Cytotechnologist	0.100	N/A	N/A

NOTE: When the limits of liability apply on a shared basis with the physicians of the group, the premium charge for the excess limits for the paramedical employees will be calculated at the level that the majority of physicians carry.

SECTION 7

STATE RATES AND EXCEPTIONS – PHYSICIANS AND SURGEONS

I. RATES

A. Rating Classes - Illinois

The following indicates the classification codes that are applicable to the rating classes on the following pages:

Rating Class	Industry Class Codes		
3	80244	80266	80420
4	80151		
6	80167	80277	
12	80153		
13	80475(C)		

B. Physicians and Surgeons Professional Liability Rates

1. Claims-Made Rates by Year

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	8,177	14,510	18,732	20,844	22,955
4	9,760	17,677	22,955	25,593	28,232
6	13,244	24,643	32,243	36,043	39,843
12	30,343	58,843	77,842	87,342	96,842
13	33,510	65,176	86,287	96,842	107,397

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	6,277	10,710	13,666	15,144	16,621
4	7,385	12,927	16,621	18,469	20,316
6	9,824	17,804	23,123	25,783	28,443
12	21,793	41,743	55,043	61,693	68,342
13	24,010	46,176	60,954	68,342	75,731

Territory 003 – Remainder of State

Class Code	$250,000 / $750,000				
	1	2	3	4	5+
3	5,391	8,937	11,301	12,484	13,666
4	6,277	10,710	13,666	15,144	16,621
6	8,228	14,612	18,868	20,996	23,123
12	17,804	33,763	44,403	49,723	55,043
13	19,577	37,310	49,132	55,043	60,954

1. Claims-Made Rates by Year (cont.)

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$250,000 / $750,000 1	2	3	4	5+
3	7,227	12,610	16,199	17,994	19,788
4	8,573	15,302	19,788	22,031	24,274
6	11,534	21,223	27,683	30,913	34,143
12	26,068	50,293	66,443	74,517	82,592
13	28,760	55,676	73,620	82,592	91,564

Territory 005 – Jackson and Vermilion Counties

Class Code	$250,000 / $750,000 1	2	3	4	5+
3	7,544	13,244	17,044	18,944	20,844
4	8,969	16,094	20,844	23,218	25,593
6	12,104	22,363	29,203	32,623	36,043
12	27,493	53,143	70,242	78,792	87,342
13	30,343	58,843	77,842	87,342	96,842

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	10,905	19,966	26,006	29,026	32,047
4	13,170	24,496	32,047	35,822	39,597
6	18,153	34,463	45,336	50,772	56,209
12	42,618	83,391	110,574	124,165	137,756
13	47,148	92,452	122,655	137,756	152,857

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	8,186	14,529	18,757	20,872	22,986
4	9,772	17,700	22,986	25,629	28,271
6	13,261	24,677	32,288	36,094	39,899
12	30,385	58,927	77,955	87,469	96,982
13	33,557	65,270	86,411	96,982	107,553

Territory 003 – Remainder of State

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	6,918	11,992	15,375	17,066	18,757
4	8,186	14,529	18,757	20,872	22,986
6	10,977	20,110	26,199	29,244	32,288
12	24,677	47,510	62,733	70,344	77,955
13	27,214	52,584	69,498	77,955	86,411

1. Claims-Made Rates by Year (cont.)

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	9,546	17,247	22,382	24,949	27,516
4	11,471	21,098	27,516	30,725	33,934
6	15,707	29,570	38,812	43,433	48,054
12	36,501	71,159	94,264	105,817	117,369
13	40,352	78,861	104,533	117,369	130,205

Territory 005 – Jackson and Vermilion Counties

Class Code	$500,000 / $1,500,000				
	1	2	3	4	5+
3	9,999	18,153	23,590	26,308	29,026
4	12,037	22,231	29,026	32,424	35,822
6	16,522	31,201	40,987	45,879	50,772
12	38,540	75,236	99,701	111,933	124,165
13	42,618	83,391	110,574	124,165	137,756

1. Claims-Made Rates by Year (cont.)

Territory 001 - Cook, Madison, St. Clair and Will Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	13,550	25,257	33,061	36,963	40,865
4	16,477	31,110	40,865	45,743	50,621
6	22,916	43,987	58,035	65,059	72,083
12	54,523	107,202	142,321	159,881	177,441
13	60,376	118,909	157,930	177,441	196,952

Territory 002 – Bond, Champaign, Clinton, DeKalb, Effingham, Franklin, Hamilton, Jefferson Kankakee, Macon, Randolph, Sangamon, Washington and Williamson Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	10,038	18,233	23,696	26,427	29,159
4	12,087	22,330	29,159	32,573	35,988
6	16,594	31,344	41,178	46,094	51,011
12	38,719	75,595	100,178	112,470	124,762
13	42,817	83,789	111,104	124,762	138,419

Territory 003 – Remainder of State

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	8,400	14,955	19,326	21,511	23,696
4	10,038	18,233	23,696	26,427	29,159
6	13,644	25,444	33,311	37,244	41,178
12	31,344	60,844	80,511	90,345	100,178
13	34,622	67,400	89,252	100,178	111,104

1. Claims-Made Rates by Year (cont.)

Territory 004 – DuPage, Kane, Lake and McHenry Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	11,794	21,745	28,379	31,695	35,012
4	14,282	26,720	35,012	39,158	43,304
6	19,755	37,666	49,606	55,577	61,547
12	46,621	91,398	121,250	136,176	151,101
13	51,596	101,349	134,517	151,101	167,685

Territory 005 – Jackson and Vermilion Counties

Class Code	$1,000,000 / $3,000,000				
	1	2	3	4	5+
3	12,380	22,916	29,939	33,451	36,963
4	15,014	28,183	36,963	41,353	45,743
6	20,808	39,773	52,416	58,737	65,059
12	49,255	96,666	128,274	144,077	159,881
13	54,523	107,202	142,321	159,881	177,441

2. Extended Reporting Period Endorsement (Tail Coverage)

Extended Reporting Period (Tail) Factors
By Month

Claims-Made
Year

	1	2	3	4	5	6	7	8	9	10	11	12
1	0.150	0.230	0.310	0.380	0.450	0.520	0.590	0.660	0.730	0.800	0.870	0.940
2	1.010	1.080	1.150	1.220	1.280	1.340	1.400	1.460	1.520	1.580	1.640	1.700
3	1.730	1.760	1.790	1.820	1.850	1.880	1.900	1.920	1.940	1.960	1.980	2.000
4	2.030	2.067	2.100	2.133	2.167	2.200	2.233	2.267	2.300	2.333	2.367	2.400
5	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400	2.400

Example: An insured who has a third year claims-made policy and decides to cancel after three months have elapsed would purchase tail coverage at the year 3, three month factor (1.790), times the mature claims-made annual rate in effect at policy issuance. For claims-made year 5 and over the 2.400 factor applies.

C. Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate. Excess limits are only offered above underlying limits of $1,000,000.

Factors for limits above $1 Million/$3 Million Primary:

	$1M/$3M Primary	
EXCESS LIMITS	Classes 1 – 8	Classes 9 – 15
$1M	0.1977	0.2535
$2M	0.3164	0.4040
$3M	0.4055	0.5169
$4M	0.4723	0.6016
$5M	0.5324	0.6779

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

II. STATE EXCEPTIONS

A. Policy Issuance

If the policy is written through a purchasing group, the following notice will be shown on the coverage summary or cover page of the policy in at least 10 point type (12 point type shown):

This policy is issued through [Name of Purchasing Group].

B. Rules

III. STATE REQUIREMENTS

A. Policy Issuance

1. The Illinois State Amendatory Endorsement must be attached to the policy at the time of issuance.

B. Rules